STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155029	B. WI	NG		10/10/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY NURSING AI	ND REHABILITATION CENTER			16TH ST APOLIS, IN 46218		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was Complaint IN0	for the Investigation of 0116211.	F00	000			
	Complaint IN0	00116211					
	•	. Federal/state					
		elated to the allegations					
	are cited at F1						
	are cited at 1 1	or and roos.					
	Survey dates:	October 9 & 10, 2012					
	Facility number	ar: 000012					
	Provider numb						
	AIM number:						
	, and marrison.	10021 1000					
	Survey team:						
	Christi Davids	on RN-TC					
	Lora Brettnach						
	Lora Brottingo	101, 1111					
	Census bed ty	vpe:					
	SNF/NF: 104	-					
	Total: 104						
	Census payor	type:					
	Medicare: 15	71					
	Medicaid: 80						
	Other: 9						
	Total: 104						
	Sample: 5						
	·						
	These deficier	ncies reflect state					
	findings cited	in accordance with 410					
	IAC 16.2.						
I	I						I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

5ISI11

Facility ID:

TITLE

000012

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155029	A. BUILDING B. WING	00		TE SURVEY MPLETED 10/2012
	PROVIDER OR SUPPLIE	R ND REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, Z 16TH ST APOLIS, IN 46218	CIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO DEFICIENC	ON SHOULD BE	(X5) COMPLETION DATE
	Quality review Williams, RN	10/15/12 by Suzanne				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 2 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV. A BUILDING (COMPLETED)			
		155029	A. BUILDING B. WING		10/10/2012
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	5600	T ADDRESS, CITY, STATE, ZIP CODE E 16TH ST ANAPOLIS, IN 46218	•
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LIGHT DESCRIPTION OF DEFORMATION OF THE PROPERTY OF T	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F0157 SS=D	483.10(b)(11) NOTIFY OF CHA (INJURY/DECLIN A facility must im resident; consult physician; and if legal representati member when the the resident whic the potential for r intervention; a sig resident's physica status (i.e., a dete or psychosocial s threatening condi complications); a significantly (i.e., existing form of tr consequences, o of treatment); or a discharge the res specified in §483 The facility must resident and, if kr representative or when there is a c roommate assign §483.15(e)(2); or under Federal or specified in parage The facility must update the addre the resident's leg interested family	mediately inform the with the resident's known, notify the resident's ve or an interested family ere is an accident involving the results in injury and has equiring physician gnificant change in the al, mental, or psychosocial erioration in health, mental, tatus in either life tions or clinical need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or dident from the facility as a decision to transfer or dident from the facility as a change in room or ment as specified in a change in resident rights State law or regulations as graph (b)(1) of this section.	TAG	DEFICIENCY)	DATE
	physician and emesis and loc	rd review and acility failed to notify a a resident's family of ose stools, and the notify the physician	F0157	F157 Notify of changes This provider ensures the resident, resident's physician	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 3 of 18

AND PLAN OF CORRECTION 155029 NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not limited to be indicated in the process of the process o
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 INDIANAPOLIS, IN 46218 ID PROVIDERS PLAN OF CORRECTION (CAS) (COMPLETION SHOULD BE COMPLETED TO SHOU
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 ID PROVIDERS PLAN OF CORRECTION (CX5) COMPLETION (COMPLETION DATE ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION EACH CORRECTION (CX5) COMPLETION DATE TAG STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION EACH CORRECTION (EACH CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION (CX5) COMPLETION DATE TAG PROVIDERS PLAN OF CORRECTION (CX5) COMPLETION DATE TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION EACH CO
COMMUNITY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not 5600 E 16TH ST INDIANAPOLIS, IN 46218 ID PROVIDERS PLAN OF CORRECTION (CAS) (CAS) PREFIX TAG PROVIDERS PLAN OF CORRECTION (CAS) TAG PROVIDERS PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PREVIOUS PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PREVIOUS PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PREVIOUS PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PREVIOUS PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PREVIOUS PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PROVIDENCE PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PROVIDENCE PLAN OF CORRECTION (CAS) COMPLETION DATE OF CASC PROVIDENCE PLAN OF CORRECTION (CAS) COMPLETION D
COMMUNITY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not INDIANAPOLIS, IN 46218 ID PROVIDERS PLANOF CORRECTION (X5) COMPLETION DATE TAG PREFIX TAG PROVIDERS PLANOF CORRECTION COMPLETION DATE TAG TAG PREFIX TAG PROVIDEN ALOR COMPLETION DATE TAG PROVIDEN ALOR CACH CORRECTIVE ACTON SHOULD BE CCORPELIZEDED COMPLETION DATE TAG PREFIX TAG PROVIDEN ALOR CACH TAG C
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (AS) PREFIX (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (AS) PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (AS) PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE Tesident's legal representative or an interested family member will be notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) When the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX
when the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not Tag CROSS-REFERENCED TO THE APPROPRIATE DETICIONATION TAG PAGE CROSS-REFERENCED TO THE APPROPRIATE DETICAL PROPERTY DESCRIPTION TO THE APPROPRIATE DESCRIPTIO
when the family member could not be reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not The resident or passible in the family member will be notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
reached after a change in level of consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not an interested family member will be notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be
be notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not be notified when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be
consciousness for 1 of 5 residents reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
reviewed for physician notification. (#B) Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
(#B) Findings Include: Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not intervention; a significant change in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
Findings Include: The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not in the resident's physical, mental or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
The record for Resident #B was reviewed on 10/9/12 at 12:00 p.m. Diagnoses included, but were not decision to transfer or discharge the resident from the facility as specified in 483.12(a). What corrective action(s) will be
reviewed on 10/9/12 at 12:00 p.m. the resident from the facility as specified in 483.12(a). What corrective action(s) will be accomplished for these
biagnoses included, but were not specified in 483.12(a). What corrective action(s) will be accomplished for these
Diagnoses included, but were not corrective action(s) will be
Diagnoses included, but were not
l accomplished for those
I limited to distory of multiple cerebral 1 .
vescular accidents, demontic
directed by the denotes
nypertension, diabetes, contractures practice? Resident no longer and history of pneumonia. resides in this facility. Corrective
action/staff education on
notification of changes change in
condition and code status for staff
[MDS] Assessment dated 08/05/12 member caring for Resident B.
indicated Resident #B had no speech How will you identify other
and was severely cognitively residents having the potential
impaired. The MDS assessment to be affected by the same
indicated Resident #B needed deficient practice and what
extensive assist with two person corrective action will be taken?
physical assist with activities of daily Residents who have a change in condition have the potential to
living and had impairment to both in condition have the potential to be affected by the alleged
upper and lower extremities on one deficient practice. · Audit change
side.
appropriate notification.
Corrective action for all
A care plan dated 6/15/12 indicated, deficiencies up to and including
"severely impaired decision making termination. What measures
skillsAnticipate resident's will be put into place or what
needsCheck on resident every two systemic changes will you
hours or as needed"
deficient practice does not

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 4 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155029	B. WIN			10/10/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
COMMU					16TH ST		
COMMO	NITT NURSING AN	ID REHABILITATION CENTER		INDIAN	IAPOLIS, IN 46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	A care plan da	ted 6/15/12 indicated,			recur? · Staff education on	·	
	1	chosen to be a do not			change of condition, notification	n	
		tusCPR [cardio			of changes and code status by	/	
		uscitation] will not be			10/26/2012 by the Director of		
	1 '	_			Nursing Services and/or		
	, ,	esident is found not			designee. · All nursing staff v	vere	
	breathing or is	not responsive"			educated by the Staff		
					Development Coordinator by 10/26/12 on the difference		
	A recapitulation	n dated 08-01-2012			between Hospice and a DNR		
	through 08-31-	-2012 with a physician's			Code Status. Education include	led	
	order dated 06/08/12 indicated, "DNR [do not resuscitate]"				that all residents with DNR cod		
					status are to receive the same		
					response as any other resider		
					change of condition, other than		
		order, untimed and			cardio pulmonary arrest, unles	ss	
	dated 8/26/12,	indicated, "May send			otherwise indicated in Advanc	е	
	to E.R. [emerg	ency room] to eval			Directive. Education included		
	[evaluate] and	treat"			residents on Hospice Services		
					will have a Care Plan in place	that	
	A facility emer	gency resident transfer			has been determined by	_	
	form dated 8/2	-			resident, family, physician, and hospice services on medical	J	
		as transferred to the			treatment during a change of		
					condition other than cardio		
	hospital at 9:5	o a.m.			pulmonary arrest. · Daily revi	ew	
					by Director of Nursing Service		
		run sheet dated			and/or designee of		
	8/26/12 at 094	3 [9:43 a.m.] indicated,			documentation on residents		
	"RN reports	ot [patient] condition			including those receiving Hosp		
		ed since 2300 the			services and those with a DNF		
		Pt does not respond			code status who have a chang	je	
	ı ·	inful stimuli and makes			of condition for appropriate		
	· ·				notification and documentation		
		en given a sternal			Road to Recovery meetings to)	
	rub"				include review of change of condition. Corrective action	for	
					deficiencies up to and includin		
	A progress not	e dated 8/15/12 at 2:55			termination. How will the	ອ	
	a.m. indicated,	"non-verbal able to			corrective action be monitore	ed	
	use gestures a	ind shake head for yes			to ensure the deficient practi		
	and no to expr	•			will not recur, i.e., what quali		
			1		1	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155029	A. BUILDING	ì	00	10/10/	
		155029	B. WING			10/10/	2012
NAME OF P	PROVIDER OR SUPPLIEF	S.			DDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER			16TH ST APOLIS, IN 46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	J .	DEFICIENCY)		DATE
	a.m. indicated, quietlyAlert to no acute distress not p.m. indicated, breakfast. At amount of emetions are further emesis. A charting doci indicated physical notification at 5 and indicated physica	e dated 8/23/12 at 2:46 "Up in chair for well. Had large esis x [times] one after int back to bed. No this shift." ument dated 8/23/12 cian and family 5:00 p.m. for emesis. e dated 8/25/12 at 9:30 , "[Recorded as Late /2012 08:41 PM]CNA ing assistant] reported at res [resident] had ises stools while they in a shower. Res also esis x 1 while in bed. p noted with dried lip" e dated 8/26/12 at 7:32 , "unable to arouse. s on evening shift x 3. of 100.8, res given and it went down. res me. MD [medical			assurance program will be purinto place? Change of Condition CQI will be utilized weekly X4 then monthly thereafter for atleast 6 months. Results of the audits will be submitted to the CQI Committe for review and follow up. Action plan will be developed for compliance < 90%. Corrective action up to and including termination for issues identified Compliance date: 10/26/2012	ee on	
	in bed at this ti						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 6 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155029	B. WING		10/10/2012
NAME OF I	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP CODE	
COMMIT	NITY NI IRSING AI	ND REHABILITATION CENTER		E 16TH ST NAPOLIS, IN 46218	
	T			T T T T T T T T T T T T T T T T T T T	(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	at this time."				
	A progress no	ote dated 8/26/12 at 8:00			
		I, "MD returned phone			
		e facilityDue to the			
		g a DNR, MD wanted to			
		the family wanted him			
	sent to the ho				
		οριιαι			
	Δ progress po	ote dated 8/26/12 at 8:05			
		I, "Attempted to contact			
		ily concerning condition.			
		eft voicemail. Awaiting			
	return phone	call."			
	A	.t. d.t. d 0/00/40 at 0:00			
		te dated 8/26/12 at 9:30			
		I, "Resident lying in bed			
		useRespirations even			
		dResident laying in			
	bed with eyes	closedFamily notified			
	again. Family	requested that resident			
	be sent out to	the hospital. Order			
	obtained to se	end to E.R. to eval and			
	treat."				
	A progress no	ote dated 09/07/12 at			
		cated, "Daughter had			
	•	arding resident being			
		e hospitalDaughter			
		esident's episodes of			
		ding dates, MD			
		•			
	notificationC				
		n regarding change in			
		dition; nursing had			
	attempted to r	notify her and was			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 7 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155029	A. BUILDIN	G	00	10/10/	
		155029	B. WING			10/10/	2012
NAME OF P	ROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY NI IRSING AN	ID REHABILITATION CENTER			16TH ST APOLIS, IN 46218		
					N OLIO, IN 402 10		215
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	unable to reacl	h her upon noting					
		ess and notifying MD.					
	On second attempt to notify her, she						
	decided to have resident sent out to						
	hospital but wa						
		ner. DON [Director of					
		ined that resident has					
	DNR code stat	us and that per her					
	request he was	s sent out but that					
	otherwise DNR protocol would have						
	been to make resident comfortable"						
		ked documentation of					
		mily notification					
		dent #B's emesis and					
		corded in progress 12. The record lacked					
		of physician and					
		on of Resident #B's					
		mes from evening shift					
		ed in the progress					
	notes on 8/26/	. •					
	The record lack	ked documentation of					
	physician notifi	cation when Resident					
	• •	ıld not be reached at					
	8:05 a.m. on 8	/16/12 after his					
	significant cha	nge in level of					
	consciousness						
		view on 10/9/12 at					
	•	DoN indicated the					
		Resident #B's family					
	were not notifie	ed of the emesis or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 8 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155029	A. BUII	LDING	00	10/10/	
		100029	B. WIN		PRESIDENCE OF THE CORP.	10/10/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	loose stools on	8/25/12.					
	During an inter 10:45 a.m., Re physician indic on 8/26/12 Reshis eyes. She informed of one She indicated the family to se Resident #B seroom and call the A facility policy Change of Con 3/10 indicated, facility that all condition will be physician and facility that all conditions will be physician and the physician and	view on 10/10/12 at sident #B's attending ated she was informed sident #B did not open indicated she was only elepisode of emesis. The facility was to call the if they wanted ent to the emergency he physician back. Itiled, "Resident adition," and revised "It is the policy of this changes in resident electronic communicated to the family/responsible appropriate, timely,					
	and effective in occursAny s	itervention udden or serious					
	manifested by physical or mer communicated request for phy and /or acute communicated	sident's condition a marked change in ntal behavior will be to the physician with a rsician visit promptly are evaluation"					
	This Federal ta IN00116211.	g relates to Complaint					
	3.1-5(a)(2)						
			1				'

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 9 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029 NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 10/10/2012	
		ID REHABILITATION CENTER		E 16TH ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	HIGHEST WELL Each resident must provide the services to attain practicable physipsychosocial we the comprehensicare. Based on recointerview, the fithorough neurobtain a blood accucheck or a signs for a resident allowed accucheck or a signs for a resident's famifor 1 of 5 resident assess. Findings Include The record for reviewed on 10 Diagnoses inclimited to, history of The most received.	ust receive and the facility necessary care and or maintain the highest cal, mental, and ll-being, in accordance with ve assessment and plan of or dreview and facility failed to do a cological assessment, sugar by performing an obtain frequent vital ident with a significant of consciousness. To failed to follow up ling physician for one inutes when the ly could not be reached ents reviewed for sment and care. (#B) de: Resident #B was 0/9/12 at 12:00 p.m. luded, but were not ory of multiple cerebral ents, dementia, diabetes, contractures	F0309	F309 Provide care/services for highest we being. It is the practice of this provide provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental apsychosocial well-being, in accordance with the comprehensive assessment aplan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident practice? Resident practice in this facility corrective action/staff education notification of changes, change in condition and code status for staff member caring Resident B. How will you identify other residents having the potential to be affected by the same deficient practice as what corrective action will be	er to o nd nd e ed ent y. on for ng ny und

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 10 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			TED	
		155029				10/10/2	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
0014141		ID DELLABILITATION CENTED			16TH ST		
COMMUI	NITY NURSING AN	ID REHABILITATION CENTER	INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	' ⁻	DATE
	indicated Resid	dent #B had no speech			taken? · Residents who have	/e a	
	and was sever	•			change in condition have the		
					potential to be affected by the		
	•	MDS assessment			alleged deficient practice. A	udit	
	indicated Resid	dent #B needed			change of condition residents	for	
	extensive assis	st with two person			appropriate assessment and		
	physical assist	with activities of daily			notification. Corrective action f	for	
	1	impairment to both			all deficiencies up to and		
	_	er extremities on one			including termination. What		
	'''	CI CAUCITILICS ON ONC			measures will be put into pla		
	side.				or what systemic changes wi	ill	
					you make to ensure that the		
	A care plan da	ted 6/15/12 indicated,			deficient practice does not		
	"severely imp	paired decision making			recur? · Staff education on		
	skillsAnticipa	_			change of condition, notificatio		
	1	on resident every two			of changes and code status by	/	
		•			10/26/2012 by the Director of		
	hours or as ne	eded			Nursing Services and/or		
					designee. Staff education of	n	
	A care plan da	ted 6/15/12 indicated,			change in mental status;		
	"Resident has	chosen to be a do not			assessment to include neuro		
	resuscitate sta	tusCPR [cardio			check. Diabetic change in		
		uscitation] will not be			condition; assessment to inclu accu check. · Daily review by		
	1 '	-			Director of Nursing Services	'	
	` '	esident is found not			and/or designee of		
	breathing or is	not responsive"			documentation on residents		
					including those receiving Hosp	nice	
	A care plan da	ted 6/27/12 indicated,			services and those with a DNF		
	"Resident is at	riskof hyperglycemia			code status who have a chang		
		ia related todiagnosis			of condition for appropriate	,	
	of diabetes me	_			notification and documentation	1. •	
	oi dianetes ille	Jiitus			Corrective action for deficienci	ies	
		1 1 100 04 0040			up to and including terminatior	n.	
	· ·	n dated 08-01-2012			How will the corrective action	n	
	through 08-31-	-2012 with a physician's			be monitored to ensure the		
	order dated 06	i/08/12 indicated,			deficient practice will not rec	ur,	
		t resuscitate]"			i.e., what quality assurance		
					program will be put into plac	e?	
	A reconitulation	n dated 08 01 2012			· Change of Condition CQI will		
	•	n dated 08-01-2012			be utilized weekly X4 then		
	through 08-31-	-2012 with a physician's			monthly thereafter for atleast 6	3	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE		
		155029	B. WIN	lG		10/10/2	2012	
NAME OF I	PROVIDER OR SUPPLIE	P	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF	FROVIDER OR SUFFEIE	K		5600 E	16TH ST			
COMMU	NITY NURSING A	ND REHABILITATION CENTER		INDIAN	APOLIS, IN 46218			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		6/28/12 indicated,			months. · Results of the audi will be submitted to the CQI	ts		
		vice daily 2 times weekly			Committee for review and follo	ow		
	1	d Thursday - Call Blood			up. Action plan will be comple			
		or less than] 70 or [sign			for compliance < 90%. Correc	tive		
	for greater tha	nj 301"			action up to and including	_		
					termination for issues identifie Compliance date: 10/26/2012			
		administration record						
	dated 08-01-2	•						
		dicated the most recent						
	accucheck for Resident #B was							
	recorded on 8	/23/12.						
	A about in a la contact contact and							
	1	order, untimed and						
		, indicated, "May send						
		gency room] to eval						
	[evaluate] and	treat"						
	A facility emer	gency resident transfer						
	1	26/12 indicated						
		as transferred to the						
	hospital at 9:5							
	An ambulance	run sheet dated						
	8/26/12 at 094	3 [9:43 a.m.] indicated,						
		pt [patient] condition						
	1	ed since 2300 the						
		. Pt does not respond						
		inful stimuli and makes						
	•	nen given a sternal						
	rubBlood su	•						
	Δ hospital reco	ord dated 8/26/12						
	•	acute intra-cranial						
	•	Neurosurgery declined						
	1	Family reported to ER a						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 12 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLI		
155029		A. BUIL B. WING			10/10/	2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER				5600 E	DDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	such a massive herniation. Pt	Little to offer with e blled (sic) and unlikely to survive or a few days"					
	the following: A progress not a.m. indicated,	e dated 8/15/12 at 2:55 "non-verbal able to nd shake head for yes ess self"					
	a.m. indicated,	self and non-verbal,					
	p.m. indicated, breakfast. Ate amount of eme	e dated 8/23/12 at 2:46 "Up in chair for well. Had large sis x [times] one after nt back to bed. No this shift.					
	p.m., indicated Entry on 09/07 [certified nursir to this writer th emesis and loc were giving hin noted with eme	e dated 8/25/12 at 9:30 , "[Recorded as Late /2012 08:41 PM]CNA ng assistant] reported at res [resident] had use stools while they n a shower. Res also esis x 1 while in bed. p noted with dried lip"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 13 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL		
155029			B. WIN			10/10/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
COMMUNITY NURSING AND REHABILITATION CENTER					16TH ST APOLIS, IN 46218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	document indic vital signs on 8 were blood pre respirations 20 per minute and degrees Fahre A progress not a.m., indicated res had emesis res had a temp tylenol for temp in bed at this ti	per minute, pulse 91 I temperature 98.9					
	at this time." A facility matrix document indice vital signs on 8 were blood prespirations 18 per minute and degrees Fahre A progress not	c vital sign tracking cated Resident #B's 8/26/12 at 7:30 a.m. essure 170/90, per minute, pulse 91 I temperature 100.8					
	call back to the resident being known (sic) if the sent to the hose A progress not a.m. indicated,	e facilityDue to the a DNR, MD wanted to he family wanted him					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 14 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/10/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			STREET A 5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST IAPOLIS, IN 46218	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	No answer. Le	eft voicemail. Awaiting all."			
	a.m. indicated, unable to arous and unlabored bed with eyes again. Family be sent out to the	e dated 8/26/12 at 9:30 "Resident lying in bed seRespirations evenResident laying in closedFamily notified requested that resident the hospital. Order and to E.R. to eval and			
	document indic	vital sign tracking cated Resident #B's /26/12 at 9:30 a.m. per minute.			
	document indic vital signs on 8 were blood pre Respirations 2	c vital sign tracking cated Resident #B's /26/12 at 10:00 a.m. ssure 167/84, 2 per minute and 0.1 degrees Fahrenheit.			
	3:45 p.m. indic concerns regar sent out to the asked about re emesis, includi notificationDi communication resident's conc	•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 15 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL		
155029			B. WIN			10/10/	2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER				5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	unresponsivent On second attermined decided to have hospital but wan not do this soo Nursing] explaid DNR code state request he was otherwise DNR been to make recomfortable" During an intermined 10:05 a.m., the resident had a full assessment be done, include the body, check for any of the body, check for any of the physician and the stable. During an intermined in the stable. During an intermined and the stable.	view on 10/9/12 at ADoN indicated if a change in condition a t of the resident should ling vital signs, check k for edema, and changes. view on 10/09/12 at DON indicated if a DNR and had a lition other than ardiac, for example, he nurse should notify and provide comfort e resident's vital signs					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 16 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
155029			B. WING		10/10/2012
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
				16TH ST	
COMMUI	NITY NURSING AN	ID REHABILITATION CENTER	INDIAN	APOLIS, IN 46218	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE
	_	necks were not			
	•	Resident #B. The DoN			
		blood sugar was			
	performed on 8				
		history of diabetes and			
	i ille change in i	evel of consciousness.			
	During an inter	view on 10/10/12 at			
	_	esident #B's attending			
	•	ated she was informed			
		t Resident #B was not			
		es. She indicated she			
		facility to reach the			
		they wanted Resident			
		emergency room and			
		κ. She indicated a			
		mean not to treat.			
		when she did hear			
		facility, they indicated			
		ted the resident sent to			
	,	room; therefore, she			
	,	hone order to send			
		the emergency room.			
		5 ,			
	As of exit on 10	0/10/12 at 3:30 p.m. no			
		entation was provided			
		ck, full neurological			
		additional vital sign			
	assessment fro	om 8/26/12 at 7:30 a.m.			
	until 8/26/12 at	t 9:30 a.m. after a level			
	of consciousne	ess change for			
	Resident #B was recognized by the				
	nursing staff.	-			
	A facility policy	titled, "Resident			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet Page 17 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED			
	155029	A. BUILDING B. WING		10/10/2012			
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
	Change of Condition," and revised 3/10 indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occursAny sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and /or acute care evaluation" This Federal tag relates to Complaint IN00116211. 3.1-37(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ISI11

Facility ID: 000012

If continuation sheet

Page 18 of 18